

**STATE OF MAINE**

**BOARD OF PHARMACY**

**APPLICATION FOR  
PHARMACIST LICENSURE**



Department of Professional and Financial Regulation

Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8620  
TTY/Hearing Impaired (207) 624-8563  
Fax: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine  
Email: [kelly.l.mclaughlin@maine.gov](mailto:kelly.l.mclaughlin@maine.gov)

**APPLICATION INSTRUCTIONS  
LICENSURE BY  
SCORE TRANSFER**

**THE FOLLOWING IS INCLUDED IN THIS PACKET**

**(Please contact this office if any of these items are missing):**

- ☐ Application for licensure by Score Transfer
- ☐ NAPLEX/MPJE Registration Bulletin - [www.nabp.net](http://www.nabp.net)
- ☐ Instructions on preparing for the Multi-state Pharmacy Jurisprudence Exam
- ☐ Criminal history record check
- ☐ Credit card authorization form
- ☐ Accommodation request form (Americans with Disabilities Act)

**THE FOLLOWING IS THE APPLICATION PROCEDURE:**

- Complete the application for licensure by score transfer (check the appropriate box) as directed on the application and submit to the Maine Board along with the required fees. Please note score transfer is only valid for one year from date of examination.
- Complete the Multi-state Pharmacy Jurisprudence Examination registration form (included in the Registration Bulletin) and submit with your application for licensure. The fee for the MPJE is \$130 (payment must be made in the form of a certified bank check or money order and made payable to NABP) with an additional examination application fee of \$100 payable to Treasurer, State of Maine (VISA or MasterCard are accepted— see credit card authorization form). NOTE: NABP will NOT accept a personal checks or credit card payments.
- Once the completed applications are received at the Board office, a letter of acknowledgment will be sent to you.
- Score Transfer reports and MPJE results will be reported electronically to the Maine Board. The applicant will then be notified of a passing or failing score. If the applicant passes, a license will be issued without delay. If the applicant fails, please contact the Board Clerk for information on retaking the exam.

Questions or concerns should be directed to Kelly McLaughlin, Board Clerk at (207) 624-8620.

If you have a disability and may require some accommodation in taking this examination, be sure to fill out and submit the enclosed "request for accommodation" form along with this application. If accommodation is not requested in advance, we cannot guarantee the availability of accommodation on-site.

**APPLICATION INSTRUCTIONS  
LICENSURE BY EXAMINATION  
(NAPLEX)**

THE FOLLOWING IS INCLUDED IN THIS PACKET

(Please contact this office if any of these items are missing):

- ☐ Application for licensure by examination
- ☐ NAPLEX/MPJE Registration Bulletin - [www.nabp.net](http://www.nabp.net)
- ☐ Instructions on preparing for the Multi-state Pharmacy Jurisprudence Exam
- ☐ Criminal history record check
- ☐ Accommodation request form (Americans with Disabilities Act)

THE FOLLOWING IS THE APPLICATION PROCEDURE:

- Complete the application for licensure by examination (check the appropriate box) as directed on the application.
- Complete the NAPLEX registration form (included in the Registration Bulletin) The fee for the NAPLEX is \$360.00 (payment MUST be in the form of a certified bank check or money order payable to NABP) with an additional examination application fee of \$100 payable to Treasurer, State of Maine (VISA or MasterCard are accepted– see credit card authorization form). NOTE: NABP will NOT accept a personal checks or credit card payments.
- Complete the MPJE registration form (included in the Registration Bulletin). The fee for the MPJE is \$130.00 (payment must be made in the form of a certified bank check or money order payable to NABP) with an additional examination application fee of \$100 payable to Treasurer, State of Maine (VISA or MasterCard are accepted– see credit card authorization form). NOTE: NABP will NOT accept a personal checks or credit card payments.

**NOTE:** Please be sure to read the NAPLEX/MPJE Registration Bulletin carefully. It contains very important information about these exams. All of the above items must be submitted at the same time. The payments, however, must be made separately.

- Upon receipt, the applications will be processed. Once your completed applications have been accepted, this office will submit the appropriate registration forms directly to NABP. You will then be notified, in writing, that your applications have been accepted and forwarded to NABP.
- NAPLEX and MPJE results are reported electronically to the Maine Board. The applicant will then be notified, in writing, of a passing or failing score.

If you have a disability and may require some accommodation in taking this examination, be sure to fill out and submit the enclosed "request for accommodation" form along with this application. If accommodation is not requested in advance, we cannot guarantee the availability of accommodation on-site.



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF PHARMACY  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

Direct Tel: (207) 624-8620 Receptionist: (207) 624-8603  
FAX: (207) 624-8637 - TTY/Hearing Impaired: (207) 624-8563

John Elias Baldacci  
GOVERNOR

ANNE L. HEAD  
DIRECTOR

✓ **CHECK ONE:**

☐ Licensure by Examination (includes application review and license upon successfully passing the NAPLEX™ and MPJE) Total fee due: \$200.00 **Payable to Treasurer, State of Maine.**

☐ Licensure by Score Transfer (includes application review and license upon successfully passing the NAPLEX and MPJE) Total fee due: \$100.00 **Payable to Treasurer, State of Maine.**

**Notice regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

**Notice regarding Public Information**

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Please attach a current photograph to this application.

**COMPLETE THE FOLLOWING IN INK (TYPE OR PRINT):**

<b>Name:</b>		
<b>Contact Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone #:</b>
<b>Social Security #:</b>		<b>Date of Birth:</b>

Employment (drug stores only):

Dates: From \_\_\_\_\_ To \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

College of Pharmacy: \_\_\_\_\_

Date of graduation: \_\_\_\_\_

Date of high school graduation: \_\_\_\_\_

Number of times examined by the Board: \_\_\_\_\_

Date(s): \_\_\_\_\_

Have you ever been convicted of a crime other than a minor traffic violation?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe below in detail the crime(s), list dates(s), and submit a copy of the court judgements(s) as well as a letter from you explaining the circumstances surrounding your conviction.

Applicant's signature \_\_\_\_\_

## CERTIFICATE OF GRADUATION IN PHARMACY EDUCATION

To be completed and signed by the Secretary or Dean of the school or college of pharmacy of which the applicant is a graduate.

This is to certify that \_\_\_\_\_  
(name of applicant)  
is a graduate of the \_\_\_\_\_,  
(name of college)  
the degree of \_\_\_\_\_

having been conferred on \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, and that \_\_\_\_\_ had previously attended  
regular courses of instruction as follows:

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

From the \_\_\_\_ day of \_\_\_\_\_, to the \_\_\_\_ of \_\_\_\_\_

A total of \_\_\_\_\_ weeks.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Secretary or Dean of

Location \_\_\_\_\_

SEAL

## CERTIFICATE OF GOOD MORAL CHARACTER AND TEMPERATE HABITS

This certificate of good moral character and temperate habits must be furnished and signed by a person of good standing in the community in which he or she resides.

Date: \_\_\_\_\_

To the Commission of Pharmacy:

I, \_\_\_\_\_ of \_\_\_\_\_,  
(printed name) (city/town)

county of \_\_\_\_\_, state of \_\_\_\_\_,

being duly sworn, do say upon oath that \_\_\_\_\_,

the applicant herein named, has been personally known to me for \_\_\_\_\_

years, last past, that my acquaintance with him/her throughout that period has been sufficient to afford me ample opportunity to become fully informed as to his/her moral character and temperate habits, that he/she is not addicted to the use of alcoholic liquors or narcotic drugs so as to render him/her unfit to practice pharmacy, that he/she is of good moral character and that I recommend him/her so far as his/her character and habits are concerned, as worthy to be licensed to practice pharmacy in Maine.

Signature \_\_\_\_\_

Occupation\_\_\_\_\_

Address \_\_\_\_\_

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I agree to abide by the statutes and rules set forth by the Maine Board of Pharmacy. I have read and completed this application and I attest that all information is true to the best of my knowledge.

**SIGNATURE OF APPLICANT**

DATE \_\_\_\_\_

## AFFIDAVIT OF EXPERIENCE

State of \_\_\_\_\_, County of \_\_\_\_\_,

I, \_\_\_\_\_, a licensed pharmacist, holder of  
license number \_\_\_\_\_, issued by the \_\_\_\_\_ Board of  
Pharmacy, a resident of \_\_\_\_\_ in the county of  
*(city/town)*

\_\_\_\_\_ and state of \_\_\_\_\_,

do hereby certify that I am personally acquainted with \_\_\_\_\_,

the applicant, and that for the period of \_\_\_\_\_, from the \_\_\_\_\_

day of \_\_\_\_\_, to the \_\_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_\_, said \_\_\_\_\_

was under my direction and instruction in the compounding and selling of drugs, in the

retail drug store or pharmacy of \_\_\_\_\_,

located at \_\_\_\_\_.

Enter total number of hours worked: \_\_\_\_\_

I agree to abide by the statutes and rules set forth by the Maine Board of Pharmacy. I have read and completed this application and I attest that all information is true to the best of my knowledge.

\_\_\_\_\_  
**SIGNATURE OF APPLICANT**

\_\_\_\_\_  
**DATE**



## AFFIDAVIT OF EXPERIENCE

State of \_\_\_\_\_, County of \_\_\_\_\_,

I, \_\_\_\_\_, a licensed pharmacist, holder of

License number \_\_\_\_\_, issued by the \_\_\_\_\_ Board of

Pharmacy, a resident of \_\_\_\_\_ in the county of  
(city/town)

\_\_\_\_\_ and State of \_\_\_\_\_,

do hereby certify that I am personally acquainted with \_\_\_\_\_,

the applicant, and that for the period of \_\_\_\_\_, from the \_\_\_\_\_

day of \_\_\_\_\_, \_\_\_\_\_, to the \_\_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_\_, said \_\_\_\_\_

was under my direction and instruction in the compounding and selling of drugs, in the

retail drug store or pharmacy of \_\_\_\_\_,

located at \_\_\_\_\_.

Enter total number of hours worked: \_\_\_\_\_

I agree to abide by the statutes and rules set forth by the Maine Board of Pharmacy. I have read and completed this application and I attest that all information is true to the best of my knowledge.

\_\_\_\_\_  
**SIGNATURE OF APPLICANT**

\_\_\_\_\_  
**DATE**

## AFFIDAVIT OF EXPERIENCE

State of \_\_\_\_\_, County of \_\_\_\_\_,

I, \_\_\_\_\_, a licensed pharmacist, holder of  
license number \_\_\_\_\_, issued by the \_\_\_\_\_ Board of  
Pharmacy, a resident of \_\_\_\_\_ in the county of  
(city/town)

\_\_\_\_\_ and State of \_\_\_\_\_,

do hereby certify that I am personally acquainted with \_\_\_\_\_,  
the applicant, and that for the period of \_\_\_\_\_, from the \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_, to the \_\_\_\_\_ day of  
\_\_\_\_\_, \_\_\_\_\_, said \_\_\_\_\_

was under my direction and instruction in the compounding and selling of drugs, in the  
retail drug store or pharmacy of \_\_\_\_\_,  
located at \_\_\_\_\_.

Enter total number of hours worked: \_\_\_\_\_

I agree to abide by the statutes and rules set forth by the Maine Board of Pharmacy. I have read and completed this application and I attest that all information is true to the best of my knowledge.

\_\_\_\_\_  
**SIGNATURE OF APPLICANT**

\_\_\_\_\_  
**DATE**



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF PHARMACY  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

John Elias Baldacci  
GOVERNOR

ANNE L. HEAD  
DIRECTOR

TO: PROSPECTIVE APPLICANT  
FROM: OFFICE OF LICENSING & REGISTRATION  
RE: CRIMINAL RECORDS CHECK

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for all applicants.

***CRIMINAL HISTORY RECORDS CHECK PROCEDURE***

Attached is a form addressed to the Maine Department of Public Safety, Bureau of Identification. Please complete the applicant information section of the enclosed form and send it to the appropriate licensing board with your completed application and supporting documentation as may be necessary. **Do not send the request directly to the Department of Public Safety.**

You must provide a separate check in the amount of \$8.00, made payable to Treasurer, Maine of State as payment for your criminal history record check in addition to the licensing fees presently required. The Department of Public Safety will not accept Visa or MasterCard as payment for the Criminal History Record Check. Please note that the criminal history record will be returned to the licensing board, not the applicant.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identifications to charge a fee to government organizations for services provided. Therefore, as of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety.

Please contact the board clerk at the number below if you have questions or need assistance.

**Kelly McLaughlin**  
**(207) 624-8620**



PRINTED ON RECYCLED PAPER

PHONE: (207)624-8620  
(Office Phone)

FAX: (207)624-8637

(207)624-8563 (TTY/HEARING IMPAIRED)  
OFFICES LOCATED AT: 122 NORTHERN AVENUE,  
GARDINER, MAINE



ANNE L. HEAD  
DIRECTOR

**Make checks payable to: Treasurer, State of Maine**  
**Submit this Application with License Application**

**Name:** \_\_\_\_\_

<b>Last</b>	<b>First</b>	<b>Middle</b>
<b>Address:</b> _____		
<b>Social Security/Federal I.D. #:</b> _____		<b>Date of Birth:</b> _____
<b>Any other names used:</b> _____		

**Agency Name & Address:** Office of Licensing and Registration  
Board of Pharmacy  
35 State House Station  
Augusta, Maine 04333-0035



(207)624-8563 (TTY/HEARING IMPAIRED)  
OFFICES LOCATED AT: 122 NORTHERN AVENUE, GARDINER,  
MAINE



John Elias Baldacci  
GOVERNOR

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ANNE L. HEAD  
DIRECTOR



### AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

<b>Name:</b> (applicant fees being paid for)		
<b>Mailing Address:</b> (applicant fees being paid for)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone:</b>
<b>Name of cardholder:</b> (if other than applicant)		
<b>Mailing Address:</b> (if other than applicant)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard \_\_\_\_\_

Card number

Expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of: \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



PHONE: (207)624-8620  
(Office Phone)

PRINTED ON RECYCLED PAPER

(207)624-8563 (TTY/HEARING IMPAIRED)

FAX: (207)624-8637



ANGUS S. KING, JR.  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF PHARMACY  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035  
(207) 624-8563 (TTY/HEARING IMPAIRED)

ANNE L. HEAD  
DIRECTOR

## ACCOMMODATION REQUEST FORM

*The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Accommodations Requested for the \_\_\_\_\_ Examination.

Disability \_\_\_\_\_

Please check all that apply

- ☐ **Accessible Testing Site**
- ☐ **Separate Testing Site**
- ☐ **Braille**
- ☐ **Large Print**
- ☐ **Tape**
- ☐ **Reader as Accommodation for Visual Impairment**
- ☐ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ☐ **Reader as Accommodation for Learning Disability**
- ☐ **Scribe/Amanuensis as Accommodation for Learning**
- ☐ **Sign Language Interpreter**
- ☐ **Extended Time**
  - ☐ **Time-and-a-half**
  - ☐ **Double time**
  - ☐ **More than double time (specify) \_\_\_\_\_**
- ☐ **Use of Computer or Other Adaptive Equipment (specify) \_\_\_\_\_**
- ☐ **Other:** \_\_\_\_\_

**Signed and Dated:** \_\_\_\_\_

## DOCUMENTATION OF DISABILITY RELATED NEEDS

**If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disability condition requires the requested test accommodation.**

**If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.**

**I have known \_\_\_\_\_ since \_\_\_\_\_ in my capacity as a**

(Test applicant)

(date)

\_\_\_\_\_  
(professional title)

**The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all types)**

- ☐ **Taped test**
- ☐ **Large print test**
- ☐ **Reader**
- ☐ **Scribe/amanuensis**
- ☐ **Extended time**
  - ☐ **Time-and-a-half**
  - ☐ **Double time**
  - ☐ **More than double time** (please justify) \_\_\_\_\_
- ☐ **Separate Testing Area**
- ☐ **Use of Computer or Other Adaptive Equipment** (please specify) \_\_\_\_\_
- ☐ **Other** (please specify) \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**License #** (If applicable): \_\_\_\_\_